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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | (X3) DATE SURVEY COMPLETED 09/16/2011 | |
| NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON STREET SHERIDAN, IN46069 | | | |
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| F0000 | <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: September 12, 13, 14, 15, and 16, 2011</p> <p>Facility number: 000336 Provider number: 155376 AIM number: 100290170</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Heather Lay, R.N. (9/12, 13, 14, 15) Michelle Hosteter, R.N. (9/13, 14, 15)</p> <p>Census bed type: SNF/NF--76 Total--76</p> <p>Census payor type: Medicare--6 Medicaid--55 Other--15 Total--76</p> <p>Sample: 16</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/21/11</p> | | | F0000 | <p>Preparation or execution of this plan of Correction does not constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required under law.</p> <p>By this response, Sheridan Rehabilitation and Healthcare Center acknowledges receipt of the statement of deficiencies and alleges that it is in compliance as of 10/11/11</p> <p>Sheridan Rehabilitation and Healthcare Center reserves the right to submit documentation to refute any of the stated deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal and/or any other administrative or legal proceeding</p> <p>This plan of correction does not constitute Admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. This plan of correction is prepared solely because it is required by Law.</p> | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F0242 SS=D | <p>Cathy Emswiller RN</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to provide a resident with choices in regard to fluid restriction. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 9/14/11 at 2:00 P.M. The resident was admitted on 8/19/11 with diagnoses which included, but were not limited to, end-stage renal disease, renal dialysis, depressive disorder, and non-insulin dependent diabetes.</p> <p>The Admission M.D.S. [Minimum Data Set] assessment, dated 8/26/11, indicated the resident had a BIMS [Brief Interview for Mental Status] score of 11, which represented "moderately impaired" cognitive status.</p> <p>The September 2011 physician order</p> | | | F0242 | <p>F242 Self Determination-Right to make Choices 1. Resident #14 was discharged from the facility on 09/19/11. 2. All residents with an order for fluid restriction were identified. The dietary manager completed a Resident Preference Review including preference of division of fluids for all identified residents. See Attachment #1 3. All residents admitted with or obtaining a new order for fluid restriction will have a Resident Preference Review including preference of division of fluids completed by the dietary manager or designee within 24 hours and then quarterly. An in-service on resident rights was completed on 9/30/11. See Attachment #2 4. Medicals Records or designee will monitor that Resident Preference Reviews including preference of division of fluids were completed on admission audit and for new admits upon data entry for new fluid restriction orders on existing residents and then quarterly. Resident Preference Reviews will be submitted in monthly quality</p> | | 10/11/2011 |

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| | <p>recap [recapitulation] sheet included, but were not limited to, "1500 milliliters [ml] fluid restriction - 340 ml each meal, 120 ml each medication pass..."</p> <p>There was one Care Plan entry titled "Fluid Maintenance," dated 8/22/11. The Approaches were listed as: "1500 fluid restriction; labs per dialysis."</p> <p>In an interview on 9/15/11 at 12:45 P.M., L.P.N. #6 indicated Resident #14 was on a fluid restriction of 1500 ml. daily. She indicated staff did not keep track of the actual fluid amount consumed by the resident in a 24 hour period. The nurse indicated the resident's dialysis agency kept track of his daily fluid intake "by how much weight was taken off [fluid removed through hemodialysis]" on dialysis days. L.P.N. #6 indicated there was no record of Resident #14's actual fluid intake.</p> <p>On 9/15/11 at 1:00 P.M., the Director of Nursing [DoN] provided a Policy/Procedure titled "Clinical Programs Manual: Hydration" with revised date of 8/10. The document included, but was not limited to, the following: "Procedure: Implement individualized interventions based on resident/patient needs and goals, which promote fluid intake to maintain sufficient</p> | | | | <p>assurance meetings. See Attachment #3 Dietary Manger Responsible Medical Records to monitor Date of completion: 10/11/11</p> | | |

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| | <p>hydration...."</p> <p>In an interview on 9/15/11 at 1:20 P.M., the resident and his wife indicated they did not know how his fluid restriction worked in the facility. The resident was not asked what fluids he preferred to drink, or how he would like his fluids divided throughout the day. For this reason, Resident #14 indicated he never finished his drinks on his meal trays because he knew he should not be drinking a lot because of his kidney disease. Resident #14's wife also indicated she did not realize his fluids were divided for meal trays and medication passes.</p> <p>On 9/15/11 at 2:20 P.M., a document titled "Nutrition Services Manual: Nutrition Practice: Fluid Maintenance" with review date of 6/09 was provided by the Assistant Director of Nursing [ADoN]. The document included, but was not limited to, "The Nutrition Services and Nursing Staff are responsible for managing the delivery and recording of fluids to a resident/patient on fluid restriction..."</p> <p>3.1-3(u)(1)</p> | | | | | | |

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| F0278 SS=D | <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review, observation, and interview, the facility failed to document a resident's relevant care areas accurately and correctly within the "Minimum Data Set" [M.D.S.] assessment. This deficient practice impacted 1 of 16 residents reviewed. [Resident #39]</p> <p>Findings included:</p> <p>On 9-13-2011 at 9:15 A.M., tour was initiated with the Director of Nursing</p> | | | F0278 | <p>F-278 Assessment Accuracy/Coordination/Certified</p> <p>1. Modification of closed MDS, assessment date of 6/7/11, was completed on 9/12/11 and submitted on 9/13/11 for resident #39. See attachment #4</p> <p>2. All residents have the potential to be affected by the same deficient practice. The MDS Coordinator or designee will compare the documented score on relevant care areas on last submitted MDS to the</p> | | 10/11/2011 |

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| | <p>[DoN]. During interview at that time, the DoN indicated that Resident #39 ambulated without assistance in the hallways. Resident #39 was observed to be walking without difficulty, and without assistance, in the hallways of the facility.</p> <p>On 9-13-2011 at 10:00 A.M., Resident #39's record was reviewed. Diagnoses included, but were not limited to, dementia with behavior disturbances and hypothyroidism.</p> <p>Resident #39's "Minimum Data Set - Version 3.0" [M.D.S.] with "Assessment reference date" of 3-8-2011 and "Type of assessment: Annual" included, but was not limited to, Functional Status, Bed Mobility: self performance: Independent - no help or staff oversight at any time, Transfer: self performance: Independent - no help or staff oversight at any time..."</p> <p>Resident #39's "Minimum Data Set - Version 3.0" [M.D.S.] with "Assessment reference date" of 6-7-2011 and "Type of assessment: Quarterly" included, but was not limited to, Functional Status, Bed Mobility: self performance: Total dependence - full staff performance every time during entire 7-day period, Transfer: self performance: Extensive assistance - resident involved in activity, staff provide weight-bearing support..."</p> | | | | <p>Care Tracker One Click MDS 3.0 Report. Any areas of Noted discrepancy will be reviewed and corrected as indicated. See attachment #5</p> <p>3. Documented scores on relevant care areas on all MDS assessments will be compared to the Care Tracker One Click MDS 3.0 Report. Any areas of noted discrepancy will be reviewed and corrected as indicated prior to submission. A copy of the Care Tracker One Click MDS 3.0 Report will then be attached to the MDS. An in-service on relevant care area MDS documentation will be completed on 10/3/11 and 10/10/11. See attachment #6</p> <p>MDS Responsible DON to monitor</p> <p>4. Date of completion 10/11/11</p> | | |

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| | <p>Nurse's notes [Progress Notes] dated 5-29-2011 at 3:00 P.M., indicated Resident #39 was up ambulating in the hallways.</p> <p>Social Service [Progress Notes] dated 6-1-2011, no time, indicated Resident #39 attended the "Assessment Meeting" and was up ad lib wandering in and out of meeting..."</p> <p>On 9-14-2011 at 8:50 A.M., the Minimum Data Set [M.D.S.] Coordinator, Registered Nurse #4, was interviewed. The M.D.S. Coordinator indicated Resident #39's assessment information was incorrectly entered into the system by L.P.N. # 5 and "Section G - Functional Status" was incorrect. The M.D.S. Coordinator provided a copy of the corrected M.D.S. - Version 3.0 for assessment reference date of 6-7-2011. The corrected version indicated that Resident #39 was "independent" with bed mobility and "independent" with transfers.</p> <p>3.1-31(d)(3)</p> | | | | | | |
| F0327 SS=D | The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. | | | | | | |

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| | <p>Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake monitoring. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 9/14/11 at 2:00 P.M. The resident was admitted on 8/19/11 with diagnoses which included, but were not limited to, end-stage renal disease, renal dialysis, depressive disorder, and non-insulin dependent diabetes.</p> <p>The Admission M.D.S. [Minimum Data Set] assessment, dated 8/26/11, indicated the resident had a BIMS [Brief Interview for Mental Status] score of 11, which represented "moderately impaired" cognitive status.</p> <p>The September 2011 physician order recap [recapitulation] sheet included, but were not limited to, "1500 milliliters [ml] fluid restriction - 340 ml each meal, 120 ml each medication pass..."</p> <p>Physician's orders for 9/2011 included, but were not limited to, "1500 ml fluid restriction - 340 ml each meal, 120 ml</p> | | | F0327 | <p>F-327 SUFFICIENT FLUID TO MAINTAIN HYDRATION 1. Resident #14 was discharged from the facility on 9/19/11. 2. All residents with an order for a fluid intake monitoring were being followed. Attachment #7 3. Medical Records or designee will monitor all residents admitted with or obtaining a new order for a fluid restriction to ensure that facility guidelines in regard to fluid intake monitoring is being followed on admission audit for new admits upon data entry on intake and output monitoring will be held on 10/3/11 and 10/10/11 Attachment #8 4. Medical Records or designee will monitor all residents admitted with or obtaining a new order for a fluid restriction to ensure that facility guidelines in regard to fluid intake monitoring is being completed on admission audits and data entry for new orders one existing residents. Concerns will be submitted in monthly quality assurance meeting on all residents on fluid restriction. Medical Records responsible, Quality Assurance to Monitor. 5. Date of completion 10/11/11 Addendum: 3. Medical Records is an LPN. Designee will be the nurse on duty. Monitoring will be done weekly by the LPN. Communication to caregivers will be done daily/as needed on the Caretracker. 4. Medical Records who is an LPN will report to the QA</p> | | 10/11/2011 |

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| | <p>each medication pass..."</p> <p>A "Fluid Maintenance" care plan dated 8-22-2011, indicated "Approach: 1500 fluid restriction with nursing as department responsible for approach."</p> <p>In an interview on 9/15/11 at 12:45 P.M., L.P.N. #6 indicated Resident #14 was on a fluid restriction of 1500 ml. daily. She indicated staff did not keep track of the actual fluid amount consumed by the resident in a 24 hour period. The nurse indicated the resident's dialysis agency kept track of his daily fluid intake "by how much weight was taken off [fluid removed through hemodialysis]" on dialysis days. L.P.N. #6 indicated there was no record of Resident #14's actual fluid intake.</p> <p>On 9/15/11 at 1:00 P.M., the Director of Nursing [DoN] provided a Policy/Procedure titled "Clinical Programs Manual: Hydration" with revised date of 8/10. The document included, but was not limited to, the following: "Procedure: Implement individualized interventions based on resident/patient needs and goals, which promote fluid intake to maintain sufficient hydration...."</p> <p>In an interview on 9/15/11 at 1:20 P.M.,</p> | | | | CommitteeMonthly/Quarterly. | | |

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| | <p>the resident and his wife indicated they did not know how his fluid restriction worked in the facility. The resident was not asked what fluids he preferred to drink, or how he would like his fluids divided throughout the day. For this reason, Resident #14 indicated he never finished his drinks on his meal trays because he knew he should not be drinking a lot because of his kidney disease. Resident #14's wife also indicated she did not realize his fluids were divided for meal trays and medication passes.</p> <p>On 9/15/11 at 2:20 P.M., a document titled "Nutrition Services Manual: Nutrition Practice: Fluid Maintenance" with review date of 6/09 was provided by the Assistant Director of Nursing [ADoN]. The document included, but was not limited to, "The Nutrition Services and Nursing Staff are responsible for managing the delivery and recording of fluids to a resident/patient on fluid restriction..."</p> <p>3.1-46(b)</p> | | | | | | |

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| F0371 SS=F | <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to store a meat slicer in a sanitary condition. This had the potential to affect 76 of 76 residents who are served food from 1 of 1 kitchens.</p> <p>Findings include:</p> <p>During the initial tour on 9/12/11 at 6:30 A.M., the meat slicer was observed to be uncovered.</p> <p>During the kitchen tour on 9/13/11 at 9:15 A.M., the meat slicer was observed in the dry food storage area. The meat processor observed to be clean, but not covered. In an interview at that time, the Dietary manager indicated the meat processor was only used a few times a month. She did not indicate the last time it had been used.</p> <p>In an interview on 9/13/11 at 9:17 A.M., the Dietary Manager indicated the meat processor was usually covered. She wasn't sure why it was not covered.</p> <p>3.1-21(i)(2)</p> | | F0371 | <p>F-371 Food Procure, Store, Prepare, Serve-sanitary</p> <p>1. The meat slicer was cleaned and covered by the dietary manager on 9/13/11.</p> <p>2. The Safety and Sanitation Review was completed by the Administrator on 9/16/11 to ensure that all equipment was stored in a sanitary condition. See Attachment #9</p> <p>3. The Safety and Sanitation Review was modified to include the sanitary storage of meat slicer. The administrator or designee will continue to complete this review weekly. The dietician will continue to complete a Sanitation Audit quarterly. See Attachment #10 An in-service on sanitary equipment storage will be held on 10/3/11 and 10/10/11.</p> <p>4. Weekly Safety and Sanitation Review and quarterly dietician Sanitation Audits will be submitted in the monthly quality assurance meeting.</p> <p>Dietary Manager responsible Administrator and Dietician to monitor</p> <p>Completion date: 10/11/11</p> | | 10/11/2011 | |

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| F0514 SS=D | <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)</p> <p>B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]</p> <p>Findings include:</p> <p>A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.</p> <p>Diagnoses for Resident #16 included, but were not limited to, depression, paranoid schizophrenia and dementia. A quarterly</p> | | F0514 | <p>F-514 Records – Complete/Accurate/Accessible</p> <p>1. The Behavior Detail Report, Care Plan, MAR and Care Tracker Resident Profile for Resident #16 were reviewed to ensure that specific interventions were complete, accurate. Readily accessible, and systematically organized. An intake record was initiated on 9/15/11 for resident #14 and continues until discharge on 9/19/11. 2. The Behavior Detail Report, Care Plan, Mar and care Tracker Resident Profile were reviewed for any resident with behavioral symptoms in the last 30 days to ensure that specific interventions were accurate. All residents with a fluid restriction were identified and reviewed to ensure facility guidelines on fluid intake were being followed. 3. Licensed Nurses are to document on the back of Medication Administration Record all specific interventions used to redirected residents with disruptive behaviors prior to administration</p> | | 10/11/2011 | |

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| | <p>Minimum Data Set Assessment, dated 4/19/11, indicated Resident #16 wandered and had severely impaired decision making skills.</p> <p>A review of the September, 2011 Physician Order Summary indicated Resident #16 had an order for Haloperidol [Haldol-an antipsychotic medication] 1 mg. [milligram] P.O. [by mouth] or I.M. [intramuscular injection] every 4 hours P.R.N. [as needed] for agitation, aggression.</p> <p>The August, 2011 M.A.R. [Medication Administration Record] indicated Resident #16 received Haloperidol 1 mg. P.R.N. for agitation/aggression on the following dates: 8/6/11, 8/15/11, 8/17/11 and 8/19/11.</p> <p>A behavior monitoring "Behavior Detail Report," received from the Assistant Director of Nursing on 9/16/11 at 9:05 A.M., indicated Resident #16 had the following behaviors:</p> <p>8/6/11 at 8:00 P.M.: "Resident #16 was physically abusive to staff. The behavior was not easily altered by diversion activities, redirection or toileting." Other than "toileting", there was no indication what specific interventions were used for "diversion activities," or ""redirection,"</p> | | | | <p>of PFRN psychopharmacological medications. Medical Records or designee will monitor all residents admitted with or obtaining anew order for fluid restrictions or PRN medications. An in-service on documentation Of specific behavioral interventions and fluid intake will be held 10/31/11 and 10/10/11 See attachment #11 4. Medical Records or designee will review medication administration records in daily care review to identify any resident whom received a prn psychophamalogical medication to ensure specific interventions were documented. Medical Records or designee will review intake records on all residents on a fluid restriction in daily care review to ensure fluid intake is documented. Concerns will be submitted in the monthly QA meeting. Licensed Nursing Staff Responsible, Medical Records to monitor Date of completion 10/11/11 Addendum: 3. Medical Records is an LPN. Designee will be the nurse on duty. Monitoring will be done daily/weekly by the LPN. Communication to caregivers will be done daily/as needed on the Caretracker. 4. Licensed Nursing Staff Responsible. Medical Records who is an LPN will report to the QA CommitteeMonthly/Quarterly.</p> | | |

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| | <p>prior to the resident receiving the Haloperidal as an intervention.</p> <p>8/15/11 at 12:15 A.M.: "Resident #16 was screaming, causing excessive noise and disruptive. The behavior was not easily altered by 1:1 [one-to-one] or toileting." There was no indication what specific interventions were used for the "1:1 intervention," prior to the resident receiving Haloperidal as an intervention.</p> <p>8/17/11 at 12:30 A.M.: "Resident #16 was screaming, cursing and hitting at staff. The behavior was not easily altered by validation or toileting." There was no indication what specific interventions were used for "validation" prior to the resident receiving Haloperidal as an intervention.</p> <p>8/19/11 at 12:00 A.M.: "Resident #16 was screaming, causing excessive noise and disruptive. The behavior was not easily altered by 1:1 or toileting." There was no indication of what specific interventions were used for the "1:1 intervention" prior to the resident receiving Haloperidal as an intervention.</p> <p>Nursing progress notes for the month of August 2011 indicated on 8/6/11 at 2030 (8:30 P.M.), "Res [Resident] agitated this shift. Not easily redirected. Combative</p> | | | | | | |

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| | <p>[with] staff." There was no documentation related to what interventions were used to try and redirect the resident. There were no nursing notes for 8/15/11, 8/17/11 or 8/19/11.</p> <p>A Care Plan for behaviors, dated 8/10/10 and updated quarterly, indicated Resident #16 had a history of visual hallucinations, paranoid delusions, was resistive to care, wandered and was verbally abusive. Approaches included, but were not limited to, allow for safe wandering, explain task, talk with resident throughout care, and explain need for care to be given.</p> <p>A computer "Care Tracker" printout, received from the Assistant Director of Nursing on 9/16/11 at 9:15 A.M., listed the following interventions for Mood and Behavior:</p> <p>"When resident upset try to take to a quiet area, sit resident in recliner and stroke hair to encourage her to relax; give resident chocolate to help distract her; and resident enjoys music, especially country music."</p> <p>In an interview on 9/16/11 at 9:15 A.M., the Assistant Director of Nurses indicated these interventions were available to all staff using the "Care Tracker" system, and</p> | | | | | | |

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| | <p>automatically "popped up" on the terminal screen, requiring the nursing staff person using the system to respond.</p> <p>During an interview on 9/16/11 at 9:15 A.M., the Assistant Director of Nursing indicated there was no documentation of which interventions were used to redirect Resident #16, or which interventions worked most often during outbreaks of behaviors. The "Care Tracker" printout was only a summary of dates and times an intervention was used, but did not capture documentation of which interventions from the list that were used.</p> <p>B.1. The clinical record for Resident #14 was reviewed on 9/14/11 at 2:00 P.M. Diagnoses included, but were not limited to, end-stage renal disease, renal dialysis, depressive disorder, and non-insulin dependent diabetes.</p> <p>Physician's orders for 9/2011 included, but were not limited to, "1500 milliliters [ml] fluid restriction - 340 ml each meal, 120 ml each medication pass..."</p> <p>In an interview on 9/15/11 at 12:45 P.M., L.P.N. #6 indicated Resident #14 was on a fluid restriction of 1500 ml. daily. She indicated staff did not keep track of the actual fluid amount consumed by the</p> | | | | | | |

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| | <p>resident in a 24 hour period. The nurse indicated the resident's dialysis agency kept track of his daily fluid intake "by how much weight was taken off [fluid removed through hemodialysis]" on dialysis days. L.P.N. #6 indicated there was no record of Resident #14's actual fluid intake.</p> <p>In an interview on 9/15/11 at 1:20 P.M., the resident and his wife indicated they did not know how his fluid restriction worked in the facility. The resident was not asked what fluids he preferred to drink, or how he would like his fluids divided throughout the day. For this reason, Resident #14 indicated he never finished his drinks on his meal trays because he knew he should not be drinking a lot because of his kidney disease. Resident #14's wife also indicated she did not realize his fluids were divided for meal trays and medication passes.</p> <p>On 9/15/11 at 2:20 P.M., a document titled "Nutrition Services Manual: Nutrition Practice: Fluid Maintenance" with review date of 6/09 was provided by the Assistant Director of Nursing [ADoN]. The document included, but was not limited to the following:</p> <p>"The Nutrition Services and Nursing Staff</p> | | | | | | |

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| | are responsible for managing the delivery and recording of fluids to a resident/patient on fluid restriction..." 3.1-3(u)(1) | | | | | | |